Overview
Discussion of CHA Cost Analysis/Assumptions for HR546 & S298

In August 2015 MHPA commissioned Steve Lieberman of Lieberman Consulting Inc. to assess whether CBO would likely concur with the savings projected by Dobson, DaVanzo, and Associates in an October 2013 report they issued.

The conclusion of the Lieberman analysis is that HR546/S298 will increase, not reduce, Medicaid spending and federal costs over FY2016-FY2025. Lieberman's conclusions are based on the four reasons listed below and are discussed in greater detail in the attached memorandum.

- The Dobson/DaVanzo report makes unrealistic assumptions about the time needed to implement the new regional pediatric networks described in HR546/S298, specifically assuming these networks would:
    - Begin to operate at the start of Year 1
    - Immediately produce savings in Year 1
    - Achieve the full potential savings after Year 3
    - Start risk-based payments in year 3

  Changing to more realistic **timing** assumptions – without changing any other Dobson/DaVanzo assumptions – **changes** their 10-year estimate from saving money to **increasing** Medicaid spending.

- The Dobson/DaVanzo estimate analyzes acute care only and excludes non-acute services, making the analysis inconsistent with the language of HR546/S298, which requires providing the full range of services needed by eligible children.
    - Dobson/Davanzo studied **only** acute care spending per child, which averaged $18,750 in 2014. They **excluded** all costs for nursing facilities and long-term support services (LTSS).
    - A 2011 Kaiser Foundation study of over 400,000 children receiving LTSS found **total cost per child cost averaged over $34,000,** reflecting **acute** care costs of $18,000 plus **LTSS** costs of $16,000.

- Flawed baseline assumptions and incomplete data make their analysis unreliable.
    - Acute care data drawn from 12 states is not nationally representative of Medicaid acute and LTSS spending on medically complex children.
    - Of the 33 states identified as likely to opt-in, the report assumes ALL states opt-in and implement the program in Year 1.
    - Baseline spending appears based on uncoordinated fee-for-service utilization and ignores savings from management techniques already in wide use, such as care coordination, comprehensive case management, PCMHs, etc..

- Estimated savings rely on unrealistic assumptions: 40% reduction in inpatient hospital spending, unprecedented increase in medically complex children (from 1 out of every 15 Medicaid kids in 2008 to 1 in 9 in 2023), prescription drug costs decrease over time (as a share of spending), adequate supply of trained case managers, etc. (A more complete list is included in the attached memo.)

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